59th Medical Wing

U.S. AIR FORCE

59 MDW Anesthesia Unit Response

Information Brief
Briefer: Major Ervin
Date: 3 FEB 04

Overview

- 59 MDW/CC Follow-up Issues
  - From Step 1 Brief
- Current/Future Problem Areas

Follow-up from Step 1 Brief

- Issue: Will you continue to book the pre-op appointments in clinic or will you need CAMO to do this?
  - Finding: Pre-Procedure Clinic will continue to book

Follow-up from Step 1 Brief (con't)

- Issue: Are you counting pre-op as "visits" and coding for them? Can you get workload credit?
  - Findings:
    - No, not counting/coding; included as part of the overall bundled procedure
    - Can't get workload credit as it's an "E" code in MEPRS and procedures aren't being performed to earn minutes of service
    - Will be captured in pre-surgery guidance & testing (location "T") in new CHCS APV module
    - Professional Services billing initiative will capture pre-surgery consults to anesthesia

Follow-up from Step 1 Brief (con't)

- Issue: Will we be up to 12 starts on 1 Nov?
  - Finding: 10 starts (plus OB, trauma*, urgent room)**
    3 Jan – 12 Jan 05
    10 starts (plus OB, trauma*)** 13-21 Jan 05
    10 starts (plus OB, trauma*, urgent room)**
    24 Jan-25 Feb 05
    11+ starts (plus OB, trauma*, urgent room)**
    after 28 Feb 05

* "Trauma" responds to emergencies and runs the board

** Plus Out of OR (MRI, Spec Proc, Cath Lab, Radiation Oncology, Pain Clinic) procedures that are not included in starts

Follow-up from Step 1 Brief (con't)

- Issue: Are newly approved CRNA (contract) staff on board yet?
  - Finding: Choctaw is processing two definite hires
  - Action: Dec 04 requested support from 59 LS; MEDCOM Contracting Officer engaged for other position vacancies

Follow-up from Step 1 Brief (con't)

- Civilian Contractor Update
  - Anesthesiologists Choctaw 3 of 4 filled
  - Anesthesiologists Spectrum 4 of 5 filled
    - One more resignation planned early February
  - CRNAs Choctaw 2 of 2 in hiring process
  - CRNAs Spectrum 5 of 7 filled
    - One more resignation 1 Mar 05
    - One locum tenens CRNA working

Follow-up from Step 1 Brief (con't)

- Issue: MEPRS shows that of the 18 assigned there are 18.93 "clinically available" 46M3s.
  - Findings: Templates required updating; Nov 04 data reflects **17 assigned/11.26 available**
  - Action: MEPRS Monitor reviewed all templates & working corrections FY05

Follow-up from Step 1 Brief (con't)

- Issue: Schedule time for review areas of coding improvement in Pain Clinic
  - Action: Emily Plager reviewed a sample of records and provided staff training
    - Physicians need to acknowledge/note vital signs
    - Enhance documentation of counseling vs. time spent with patient
    - Patient new to clinic vs. new to physician

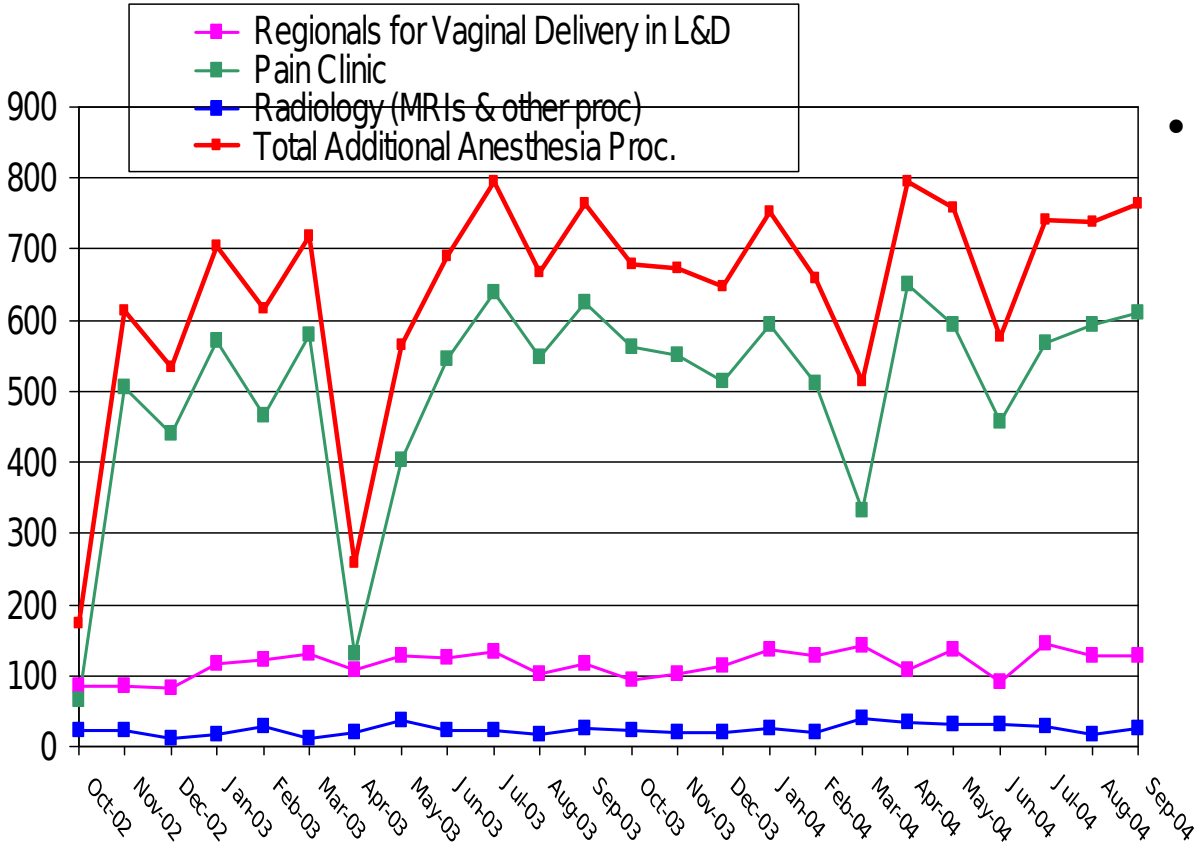
Follow-up from Step 1 Brief (con't)

- Issue: Pursue Super Bill option
  - Finding: Pain Clinic has been using Super Bill
  - Action: Created procedure templates to place on 600s to ensure all required info entered for appropriate coding

Follow-up from Step 1 Brief (con't)

- Issue: Find out why there was a big decrease in "other anesthesia" surgical support in Apr 03 & Mar 04.
  - Findings:
    - Data are collected manually and data for Pain Clinic are inaccurate – numbers recorded were NOT procedures
    - Data only reported internally on EIC
  - Action: Corrected data reported FY05 and provided MEPRS POC with explanation

Anesthesia
Other Anesthesia Oct 02 - Sep 04



- Avg # /mo (FY03 vs FY04)
  - Regionals for Vaginal Delivery
    - 111 up to 121 o +9%
  - Pain Clinic
    - 460 to 544 or +18%
  - Radiology Spt
    - 21 to 26 or+23%

- Overall, anesthesia supported +17% additional procedures (592/mo up to 692/mo)

Follow-up from Step 1 Brief (con't)

- Issue: Are you getting RVU (workload) credit for conscious sedation and MRIs?
  - Finding: Not previously, number of procedures were manually counted and reported internally on EIC
  - Action: On 15 Nov finalized process to capture out of OR anesthesia service workload/RVU as part of professional services billing initiative

Follow-up from Step 1 Brief (con't)

- Issue: Longer-term: Given that Primary Care should be doing more of pain management (especially refills), consider doing staff education every six months or so. This should take some of the workload off the anesthesia flight; should end up reducing what gets sent downtown
  - Finding: Long-term problem will require multi-disciplinary intervention to resolve
  - Action: Planned for Mar 05 work with Primary Care to integrate them in to pain management continuum of care

Follow-up from Step 1 Brief (con't)

- Issue: You stated referrals,while down from FY03, are starting to head back up. Discuss why and what you would need to mitigate/decrease this trend
  - Finding:
    - Enrollment in clinic at maximum capacity
    - Have 44% the spaced needed – working increased need in space plan (based on DoD Space Planning Criteria: Specialty Surgical Clinics)
    - Somewhat relieved when Primary Care is integrated

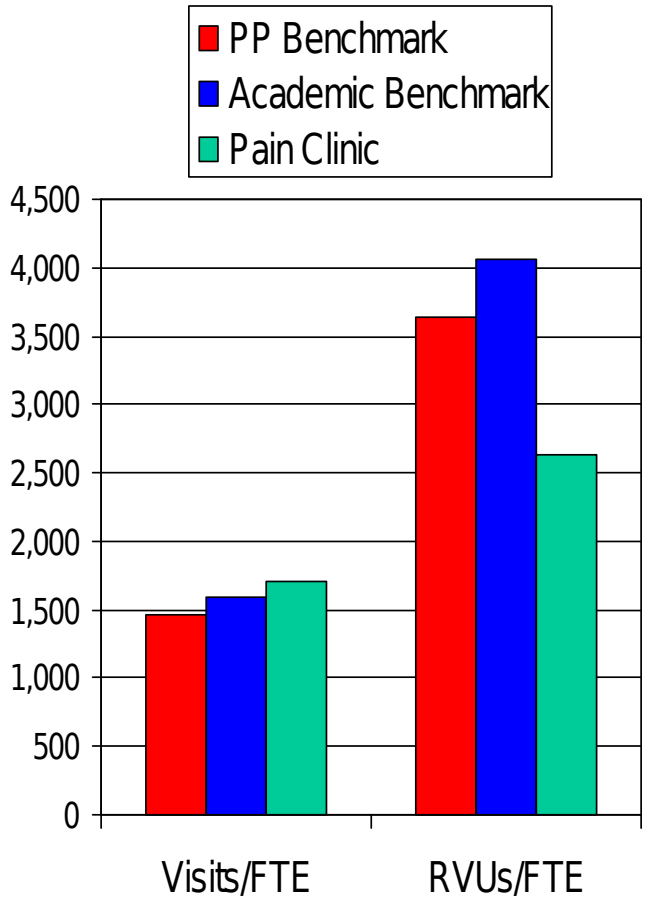
Follow-up from Step 1 Brief (con't)

- Issue: Health Plan Management Flt reported your access to care for specialty appointments was 14.7 days. You indicated you thought it was 45 days. Please provide what information you have and whether your numbers reflect NEW referrals or f/u appointments (e.g. if a new patient referral showed up today to be booked in the CAMO or by your clinic, how many days out would the first available appointment be?)

Follow-up from Step 1 Brief (con't)

- Issue: Access to care (Con't)
  - Findings:
    - As of 1 Nov - Initial appointments scheduled by CAMO
      - Delay from time consult submitted until scheduled
      - Jan 05 CHCS ATC Report avg wait 20.1 days
    - Follow-up Appoints manually scheduled by clinic, then entered into CHCS
      - 60 days for follow-up and procedures (should be 30 days)

Anesthesia
Benchmark Comparison per FTE



	Clinic Avail*
#FTEs*	1.6
FY04 Visits	2,633
FY04 Visits/FTE	1,646
Academic Benchmark (visits/FTE)	1,594
% Compared to Acad. Benchmark	103%
FY04 RVUs	4,354
RVU/Visit	1.65
RVU/FTE	2,721
Academic Benchmark (RVU/FTE)	4,065
% Compared to Acad. Benchmark	67%

* Corrected; Anesthesia estimates 1.6 FTE avail vs. MEPRS which was 0.5.

Areas of Concern
Current/Future Problem Areas

- GME
- Anesthesia Staffing Model

GME

- SAUSHEC Anesthesiology Residency
  - 32 Total residents in integrated program
  - 16 Total AF Residents/16 Total Army Residents
- RRC Status: 3-year accreditation; last accreditation 2001; RRC site evaluation July 2004
- Overall Program Health: Good
  - 83% Board Pass Rate (Written)
  - 100% on-time Graduation
  - Scores: most graduates score in top 10th percentile

GME

- Index Cases (RRC requirements for each resident):
  - 40 anesthetics for labor and delivery (incl 20 C-sections)
  - 100 anesthetics of children under age 12 (incl 15 infants)
  - 20 anesthetics for CABG
  - 20 anesthetics for major vascular procedures
  - 20 intrathoracic noncardiac cases
  - 20 open cranium procedures
  - 50 epidural anesthetics
  - 50 subarachnoid blocks
  - 40 peripheral nerve blocks
  - 25 new patient evaluations for acute, chronic or cancer pain
  - Significant experience with airway management, invasive line placement
  - Critical Care

GME

- FY 2004 Index Cases (A Snapshot):
  - 374 C-Sections in (31.1/month)
  - 79 open heart procedures (6.6/month)
  - 67 intrathoracic noncardiac cases (5.6/month)
  - 60 open cranium cases (5/month)
  - 76 major vascular procedures (6.3/month)

GME

- Case Mix and Patient Volume:
  - Limited ICU beds results in loss of GME patients
  - Limited exposure to critically sick surgical patients, especially open heart and vascular patients
    - Augmenting through rotation at UTHSC, TX Heart
  - Daily OR case starts are at RRC minimum (10-12) for adequate resident education
  - Decreased Labor and Delivery census
    - Augmenting through rotation at UTHSC

GME

- Case Mix and Patient Volume:
  - Decreased neurosurgical cases
    - Augmenting via rotation at Southwestern Medical Center
  - Diminished opportunities to perform peripheral nerve blocks at WHMC
    - Augmenting through rotation at BAMC
  - Diminished Pediatric Surgical cases
    - Augmenting through rotations at Fort Worth Children's, Corpus Christi
  - Limitations: Majority of training should occur at primary institution (per RRC); index cases cannot be provided at WHMC; number of outside rotations "maxed out"

Staffing Model

- Diagram/Figures
- Anesthesia Care Team (ACT)
  - Staff Physician with either CRNA or resident => 1 MDA:2 rooms
  - Complex subspecialty cases (I.e. peds, neuro, CT, vascular) Staff physician with resident => 1 MDA:1 room
  - Staff only cases

Staffing Model

- Anesthesia Care Team
  - Utilized in medical centers throughout USAF
  - Considered standard of care for medical center practice by USAF Consultant
- AF/SG Guidance
  - AFI 44-102 *Community Health Mgmt*
    - Physician must cosign anesthesia record (surgeon countersigns if anesthesiologist not involved in care)
    - CRNA must consult with an anesthesiologist prior to administering an anesthetic to **ASA 3 or above** and **children under age 2**

Staffing Model

Anesthesia Staffing Grid 2005 Created 1-13-05

Month	*JAN*	*FEB*	MAR	APR	*MAY*	*JUN*	JUL	AUG	*SEP*	*OCT*
MD staff (AD and Contractor)	21	20	20	20	20	20	25**	25**	25**	25**
AD MD Staff Deployed	6	6 (3 MID)	3	3	6	6 (3 MID)	3	3	6	6 (3 MID)
Leave	0	2	2	2	0	2	3	3	3	3
TDY/Military Duty	0	2	2	2	0	2	2	2	2	2
MD Staff Available for OR	**15**	**10(13 MID**	**13**	**13**	**14**	**10(13 MID**	**17**	**17**	**14**	**14(17 MID)**
CRNA Staff	10	10	19	18	17	19	18	18	16	16
CRNA Staff Avail. for OR	**4**	**4**	**10**	**9**	**8**	**10**	**9**	**9**	**7**	**7**
Residents	5	5	5	5	5	5	5	5	5	5
OR Starts	**11**	**11(14 MID**	**14+**	**14+**	**14+**	**14+**	**????***	**????***	**????***	**????***

MD Staff available for the OR are allocated in the following way:

1 - Board Runner/1085

1 - OB Anesthesia Staff

2 - Pain Clinic

2 - Call Coverage

2-3 ORs 1:1 coverage for subspecialty cases, solo staff room, new residents (July requires more)

Remainder of staff cover ORs (1:2 ratio)

1 - Staff coverage of Out-of-OR procedures and ICU

1 - Program Director, 1 - Flight Commander, 1 - Anesthesiology Consultant *(new)*, 1 - Chairman of Conscious Sedation Cmte -- NO TIME FOR ADMINISTRATIVE DUTIES

Italics **Potential overlap for deployment, consider decreasing starts by one to two rooms.**

* Would like to start doing humanitarian missions again as well as give time for research to staff.

** Dependent on getting staff in next assignment cycle and holding onto contractors.

Recommendations for maximizing output from our department:

a) Goal of 24-25 MD staff

b) Goal of 18-19 CRNA's

With this we can support the Air Force and 59 MDW to the highest level, as the flagship should be.

Staffing Model

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
AD CRNAs										
#positions authorized:	17	17	17	17	17	17	17	17	17	17
actual #filled/assigned: (all M3s)	13*	17*	17	17	16	14	13	13	13	13
#deployed:	8	8	4	4	4	0	0	0	2	2
#Inprocessing/Orienting	1	5	0	0	0	?	?	0	0	0
Subtotal:	**4***	**4***	**13**	**13**	**12**	**14**	**13**	**13**	**11**	**11**
T-Next contract / Choctaw										
#positions authorized:	7 + 2	7 + 2	7 + 2	7 + 2	7 + 2	7 + 2	7 + 2	7 + 2	7 + 2	7 + 2
actual #filled:	5 + 0	5 + 0	5 + 0	5 + 0	5 + 0	5 + 0	5 + 0	5 + 0	5 + 0	5 + 0
Subtotal:	5 + 1 locum	5 + 1 locum	5 + 1 locum	5	5	5	5	5	5	5
Staffing Projections										
Active Duty:										
projected graduate gains (M1s):	1	0	0	0	0	0	0	0	0	0
projected PCS gains (M3s):	0	4	0	0	0	#	#	#	0	0
PCS/separation/retirement losses:	0	0	0	0	1	2	1	0	0	0
T-Next contractors / Choctaw:										
projected graduate gains:	0	0	0	0	0	0	0	0	0	0
projected experienced gains:	0	1 ?	1	0	0	0	0	0	0	0
projected losses:	0	0	1	0	0	0	0	0	0	0
PFD:	**10**	**10**	**19**	**18**	**17**	**19**	**18**	**18**	**16**	**16**

Staffing Model

- 9 CRNAs are needed to start a respective duty day (The remainder are available to work in the OR):
  - 2 - OB
  - 1 - Post Call
  - 1 - Breaks
  - 1 - Preoperative Clinic
  - 2 - Leave
  - 1 - TDY
  - 1 - Military Duties

Staffing Model

- Implications
  - Allows for potential increase in supported daily OR starts
  - Anesthesia Care Team maintained throughout process facilitating safe expansion of services
  - Need for corresponding increase in support infrastructure to accommodate throughput
    - More ICU beds
    - More Same Day Surgery Capacity
    - More ward beds
    - More PACU staffing
    - Additional Funding

Conclusion

- Questions/Concerns